Instructions for Parents Completing Medication Administration Form

If your child requires medication to be supervised or administered by school staff for at least one month or medication in an emergency (other than an epinephrine auto-injector), you and your doctor must complete the Medication Administration Form. No medications will be given to your child without a signed medication administration form.

Parent/Legal Guardian:

- ***Complete and sign Section A** of the Medication Administration Form and return the form to the school prior to school starting in September or when your child is started on a medication.*
- ***Have your family doctor complete and sign Section B** of the Medication Administration Form. Your doctor needs to clearly state the medical condition, the name of the medication, the amount of medication to be given, how often it is to be given, consequences of a missed dose, important side effects and/or drug reactions.*

***Provide the medication in its original container** clearly labelled with:*

- *Child's name*
- *Medication name*
- *Dosage*
- *Expiry date*

Ask your pharmacist for an extra labelled container for prescription medications (so you can supply one for school use) and an accurate measuring spoon or cup for liquid medications.

The school principal will be informed of the medication to be administered and will discuss this with school staff. The school's Public Health Nurse is available for consultation if there are any questions about the medication.

MEDICATION ADMINISTRATION FORM

A) PARENT/GUARDIAN – COMPLETE AND SIGN

STUDENT'S NAME (Last, First)	**DOB** (Day/Mo/Year)
MEDICAL CONDITION ☐ **Blood Clotting Disorder** ☐ **Heart Condition** ☐ **Seizure Disorder** ☐ **Severe Asthma** **Other:** _____	

PHYSICIAN	**PHONE**	**PHN/CARE CARD #**
PARENT/GUARDIAN	**DAYTIME PHONE** **CELL PHONE**	**EMAIL ADDRESS**

I request the school to give medication as prescribed to my child. I understand I must provide the medication in a sealed original container that is clearly labelled. I will notify the school promptly of any changes in medications ordered.

SIGNATURE OF PARENT/GUARDIAN	**DATE** (Day/Mo/Year)

B) PHYSICIAN – COMPLETE AND SIGN

CONDITION(S) WHICH MAKE MEDICATION NECESSARY:_____

_____

NOTE:

✦ **Staff may only administer student medication that has been prescribed by a physician; staff shall not** administer non-prescribed medication as per Administration of Oral/Topical Medication Policy 5141.20 and Regulation 5141.20

NAME OF MEDICATION	**DOSAGE**	**DIRECTIONS FOR USE**
1)		
2)		
3)		

ADDITIONAL COMMENTS, POSSIBLE REACTIONS, CONSEQUENCES OF MISSING MEDICATION, ETC.

SIGNATURE OF PHYSICIAN	**DATE** (Day/Mo/Year)

DOCUMENTATION FORM FOR ADMINISTRATION OF SHORT-TERM ORAL/TOPICAL MEDICATION AT SCHOOL BY STAFF

***SHORT-TERM DEFINED AS LESS THAN 1 MONTH*

EACH SCHOOL STAFF MEMBER WHO IS RESPONSIBLE FOR THE ADMINISTRATION OR SUPERVISION OF THE MEDICATION MUST REVIEW THE INFORMATION BELOW, THEN SIGN AND DATE.

(Medication must be in original container with child's name, instructions, dosage and expiry date.)

STUDENT NAME	
PRESCRIPTION MEDICATION	
TIME OF DAY	
DOSE	
STAFF NAME	
STAFF SIGNATURE	*DATE (d/m/y)*
STAFF NAME	
STAFF SIGNATURE	*DATE (d/m/y)*
STAFF NAME	
STAFF SIGNATURE	*DATE (d/m/y)*
PARENT/GUARDIAN NAME	
PARENT/GUARDIAN SIGNATURE	*DATE (d/m/y)*

Parent/Guardian signature required for **short-term administration of oral/topical medication*

*I give permission for the individuals **named above** to administer oral/topical medication to my child on a short term basis.*

Parent/Guardian Name *Parent /Guardian Signature* *Date*

DOCUMENTATION FORM FOR ADMINISTRATION OF

SHORT-TERM ORAL/TOPICAL MEDICATION AT SCHOOL BY STAFF

*THIS PAGE MUST REMAIN ATTACHED TO ORIGINAL PAGE THAT CONTAINS PARENT/GUARDIAN SIGNATURE AND INSTRUCTIONS)

STUDENT NAME	
PRESCRIPTION MEDICATION	

DATE	TIME	DOSE	STAFF SIGNATURE	COMMENTS

This information is subject to and protected by the Freedom of Information and Protection of Privacy Act.

DOCUMENTATION FORM FOR ADMINISTRATION OF LONG-TERM ORAL/TOPICAL MEDICATION AT SCHOOL BY STAFF

***LONG-TERM DEFINED AS MORE THAN 1 MONTH*

EACH SCHOOL STAFF MEMBER WHO IS RESPONSIBLE FOR THE ADMINISTRATION OR SUPERVISION OF THE MEDICATION MUST REVIEW THE INFORMATION BELOW, THEN SIGN AND DATE.

(Medication must be in original container with child's name, instructions, dosage and expiry date.)

STUDENT NAME	
PRESCRIPTION MEDICATION	
TIME(s) OF DAY	
DOSE	
STAFF NAME	
STAFF SIGNATURE	*DATE (d/m/y)*
STAFF NAME	
STAFF SIGNATURE	*DATE (d/m/y)*
STAFF NAME	
STAFF SIGNATURE	*DATE (d/m/y)*
STAFF NAME	
STAFF SIGNATURE	*DATE (d/m/y)*

**Parent/Guardian signature required for long-term administration of oral/topical medication*

Parent/Guardian Name *Parent /Guardian Signature* *Date*

_____ _____ _____